HUGHES
Your Bridge to Better Health
PHYSICAL THERAPY

Authorization to Treat/Patient Information

Patient Name: _____ Gender: **M / F** Date of Birth: _____ Age: _____

Patient Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address (for appointment reminders): _____

Social Security No.: _____ Employer: _____

Referring Physician: _____ Primary Physician: _____

Are you currently receiving (or have received in the previous two months) ***HOME HEALTH*** services? **Yes / No**

Person to contact in case of emergency: Name/Relationship: _____ Phone: _____

Please initial the following:

_____ I hereby assign all insurance benefits for services rendered to which I am entitled to be paid directly to Hughes Physical Therapy. I understand that if my insurance company/third party payer denies payment or makes partial payment, I am responsible for the balance.

_____ I hereby authorize the release of medical records to Hughes Physical Therapy and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

_____ I understand that I am legally responsible for payment of all services rendered by Hughes Physical Therapy. If my insurance is being billed, I will be responsible for paying any deductible amounts. I understand that co-payments are due at the time of service. (Worker's Compensation patients will be responsible for the bill if claim is denied and private insurance has deductible/co-insurance/copay amounts or if they are uninsured).

_____ Due to the nature of our specialty and to assist with patient flow, we require a 24-hour advanced notice of appointment cancellations. If you fail to cancel or do not show for your appointment, we will assess a **$20.00 fee.** You will be responsible for paying this fee as it cannot be billed to your insurance company. ***Two (2) consecutive no-shows or late cancellations will result in cancellation of all remaining appointments and all future appointments will be scheduled on a day-to-day basis.***

_____ HIPPA: Hughes Physical Therapy will follow Federal Privacy laws. A copy of the Privacy Policy is available to me upon request.

_____ I hereby authorize Hughes Physical Therapy to provide treatment as prescribed by my physician.

_____ **Checks returned for non-sufficient funds (NSF) will be assessed a $30 fee, plus any other bank associated fees.**

Signature of Patient or Guardian: _____ Date: _____